he/she be made helpless? If, Social Services are loathe to displace relatives as the next of kin, we as clinicians ought to highlight this reluctance in joint meetings with Social Services. I would also disagree that once initiated, the process is long and complicated. Given its seriousness it is of necessity time-consuming involving submission of a report and possible court appearances, but our primary concern must remain the patients, whether or not we perceive the relatives as awkward or difficult. One of the strengths of the current Mental Health Act is that the rights of individuals and of the nearest relative are protected.

My colleagues from Social Services and I have recently been involved in a case where it became necessary to ask the court to displace a young lady's mother as next of kin on the grounds that she unreasonably objected to making an application for treatment. The court agreed with our views and the nearest relative was displaced. Since then the relationship between the displaced relative and the clinicians has improved dramatically!

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Mental state at discharge

DEAR SIRS

We are in complete agreement with Akerman & McCarthy (*Psychiatric Bulletin*, April 1992, **16**, 216–217) that mental state at discharge should be included in all discharge communications from hospital. The authors highlight the contribution such a record could make to formal audit. A record of mental state at discharge has several other important benefits: it focuses the mind of the clinician on the therapeutic process which has just occurred, thus, encouraging him(her) to audit the care he(she) has delivered; it helps other health care workers assess future changes in the patient's mental state; it helps future clinicians plan more effective treatments by giving an explicit indication of therapeutic response (rather than the usual implicit assumption that the patient probably improved if he/she was discharged); and it is very useful in retrospective case note research. We believe that recording mental state at discharge should be part of routine psychiatric practice and we hope that if we repeated our audit of discharge summaries (Craddock & Craddock, 1990) in five years' time that we would find this item recorded in significantly more than one quarter of summaries.

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Reference

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Violence and junior psychiatrists

DEAR SIRS

Drs Kidd and Stark (*Psychiatric Bulletin*, March 1992, **16**, 144–145) have addressed a potentially important area of concern to us all, particularly in the wake of the CTC working party recommendations with respect to violent incidents (1991). My concern is that they have perhaps not gone far enough.

The Health Services Advisory Committee report (1987) stated that although defining violence is difficult, it is an essential task for anyone involved in the management and prevention of violent incidents. I believe the same applies to those engaged in research in this field. Drs Kidd and Stark fail to define what they mean by "physical assault" or "imminent danger". Assault in law means reasonable fear or apprehension of the unjustified use of force. Any unwanted contact is a battery. These definitions are themselves limited in their usefulness but what is urgently required, if we are to represent the problem accurately and reach a sensible conclusion, are specific and detailed data. The circumstances of each incident, the physical environment in which it took place and the state of mind of the assailant, are vital pieces of information if any meaningful attempt at prevention is to be made. This is not to confuse the issue with that of the prediction of dangerousness, but merely to recognise that assaultive behaviour is complex and depends upon many factors, and if we choose not to acknowledge this then we run the risk of misrepresenting the facts, and doing both ourselves and our patients a grave disservice. For instance, major mental disorder leads to violence far less frequently than intoxication with alcohol or other substances. The relationship between mental illness and violence is far from clear and forms the basis of much current research. Psychiatrists should be aware of the possibility of fuelling public misconceptions about the "dangerous madman".

The authors make the point that following 20 out of a total of 28 incidents, no support was offered. This is hardly surprising in light of the fact that only five were reported. The reasons for failure to report the other 23 episodes would have been of interest for as Barczak & Gohari (1988) pointed out, there are wide-ranging implications from this, for staff and patients alike, and even when an efficient system of care for victims exists, problems arise as staff are reluctant to use it.

The opening statement of the article that "aggression directed towards health care workers has been

widely discussed" is perhaps misleading. It has been aired as an issue in a variety of ways and there is a growing body of literature on the subject reflecting the concern and anxiety which it quite rightly provokes. What is needed to ensure that it is widely discussed, and in particular with regard to the risks to junior psychiatrists and our colleagues in other specialities, is systematic and well constructed research to form the foundation to support the argument for change.

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Reply

DEAR SIRS

Dr Humphreys overestimates the modest aims of our study. There has been much recent focus on assaults to staff, including an editorial in the *British Medical Journal* and features in the *Health Service Journal* and *BMA News Review*. Our intent was to discover whether violence at work was also an important issue to junior doctors working in psychiatry, and whether elementary Health and Safety Executive guidelines were being met. The intensity of the responses we received left us in no doubt that many doctors were extremely concerned (Stark & Kidd, 1991), and that guidelines were unevenly applied.

Dr Humphreys identifies correctly the limitations of retrospective studies. We did not include discussion of retrospective study design as readers were likely to be familiar with the methodological difficulties. There are many other problems inherent in a retrospective postal questionnaire survey but, as always, the art of critical reading of the literature involves deciding what practical conclusions can be drawn from a study despite innate design constraints.

The difficulty in applying operational definitions to a retrospective self-completion survey was a concern to us, although we designed the questionnaire taking into consideration the Health and Safety Executive's definition of violence, "any incident in which an employee is abused, threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment". We were careful not to imply that we had reliable data on the incidence of assaults. Demonstrating that many doctors had felt in danger of assault, or had actually been physically assaulted (the wording used in our questionnaire) was sufficient to meet our aims.

Our purpose in stressing the number of incidents reported, and the number after which counselling was offered, was not as transparent as we had hoped. We wished to demonstrate the shortfall in reporting episodes, and consequently in doctors receiving support and guidance after potentially serious events. Lack of counselling was not solely caused by junior doctors failing to report episodes. Several doctors described senior colleagues who felt that feedback was neither desirable nor necesssary.

Alcohol is a common component in violent crime. The literature on antecedents of violent behaviour in hospitals is extensive, however, and alcohol is not implicated in the majority of assaults. It is evident that limited reliance should be placed upon predictors of dangerousness (Monahan, 1989). Rather, as we have stressed in the past, hospitals should strive to create systems which make the working environment as safe as possible for both staff and patients (Stark & Kidd, 1991).

It is sobering that Dr Humphreys feels that research into the field may strengthen negative stereotypes. The enthusiasm other public services bring to the issue offers a striking contrast to our hesitancies. Awareness of violence and expertise in dealing with potential incidents protects both staff and patients. We should resist any impulse to lower the profile of safety within the NHS.

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A full list of references is available on request to Dr Kidd.

Clozapine-related seizures

DEAR SIRS

We would like to add to the recent correspondence in the *Psychiatric Bulletin* (Launer, 1992, **16**, 45–46 and Rigby & Pang, 1992, **16**, 106) concerning patient compliance with clozapine treatment by